

1 EDMUND G. BROWN JR.  
Attorney General of California  
2 GLORIA A. BARRIOS  
Supervising Deputy Attorney General  
3 M. TRAVIS PEERY  
Deputy Attorney General  
4 State Bar No. 261887  
300 So. Spring Street, Suite 1702  
5 Los Angeles, CA 90013  
Telephone: (213) 897-0962  
6 Facsimile: (213) 897-2804  
*Attorneys for Complainant*

7  
8 **BEFORE THE**  
9 **BOARD OF REGISTERED NURSING**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2011-421

13 **MARIANNE M. NAHAG**  
22928 N. Shadow Pl.  
Castaic, CA 91384  
Registered Nurse License No. 699897

**A C C U S A T I O N**

14 Respondent.

15  
16 Complainant alleges:

17 **PARTIES**

18 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
19 official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department  
20 of Consumer Affairs.

21 2. On or about March 12, 2007, the Board of Registered Nursing issued Registered  
22 Nurse License Number 699897 to Marianne M. Nahag (Respondent). The Registered Nurse  
23 License was in full force and effect at all times relevant to the charges brought herein and will  
24 expire on June 30, 2010, unless renewed.

25 **JURISDICTION**

26 3. This Accusation is brought before the Board of Registered Nursing (Board),  
27 Department of Consumer Affairs, under the authority of the following laws. All section  
28 references are to the Business and Professions Code unless otherwise indicated.

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1 **SUMMARY OF FACTS**

2 9. On or about October 29, 2008, Respondent was working a shift from 0700 hours to  
3 1900 hours at Hollywood Presbyterian Hospital. At or about 1100 hours an additional nurse,  
4 Angie Park, arrived at the hospital. Upon the arrival of Nurse Park, Respondent gave Nurse Park  
5 the eight (8) patients Respondent had been caring for and advised Nurse Park that the patient in  
6 room 430 needed a blood transfusion. Upon Nurse Park's arrival, Respondent became the charge  
7 nurse. When Nurse Park received the blood bag for the patient in room 430, she went to the  
8 nurses' station where she and Respondent verified the order with the information on the blood  
9 bag. After the two nurses had verified the information at the nurses' station, Nurse Park left with  
10 the blood bag to start the transfusion. Respondent and Nurse Park never confirmed at the  
11 patient's bedside, as required by hospital policy, that the patient's name, date of birth, and  
12 medical record number on the patient's wristband matched the information on the transfusion  
13 bag.

14 10. The blood transfusion was for the patient in room 430 but Nurse Park took the blood  
15 to "Patient AA" in room 437. At or about 1545 hours, Nurse Park checked Patient AA's vital  
16 signs and began the transfusion. Patient AA's blood type was O-positive but the blood he  
17 received was A-positive.

18 11. As a result of receiving A-positive blood during the unordered blood transfusion,  
19 Patient AA suffered a severe hemolytic reaction and died on October 29, 2008 at 2056 hours.

20 **FIRST CAUSE FOR DISCIPLINE**

21 **(Gross Negligence)**

22 12. Respondent is subject to discipline under Code section 2761, subdivision (a)(1) on the  
23 grounds of unprofessional conduct as defined under California Code of Regulations, title 16,  
24 section 1442, in that on or about October 29, 2008, while on duty as a registered nurse at  
25 Hollywood Presbyterian Hospital, Respondent was grossly negligent in the following respect:

26 13. Respondent failed to follow established hospital policy and procedure while  
27 conducting a pre transfusion patient identification check. Respondent failed to check the patient's  
28 identifiers (name, date of birth, and medical record number) against the unit of blood at the

1 patient's bedside. As a result of this failure, blood was given to the wrong patient, the patient  
2 developed a sever hemolytic transfusion reaction, and died. Complainant refers to and  
3 incorporates all the allegations contained in paragraphs 9 – 11, as though set forth fully.

4 PRAYER


5 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
6 and that following the hearing, the Board of Registered Nursing issue a decision:

7 1. Revoking or suspending Registered Nurse License Number 699897, issued to  
8 Marianne M. Nahag;

9 2. Ordering Marianne M. Nahag to pay the Board of Registered Nursing the reasonable  
10 costs of the investigation and enforcement of this case, pursuant to Business and Professions  
11 Code section 125.3; and

12 3. Taking such other and further action as deemed necessary and proper.  
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15 DATED: 11/8/10

16 *for*   
17 LOUISE R. BAILEY, M.ED., RN  
18 Interim Executive Officer  
19 Board of Registered Nursing  
20 Department of Consumer Affairs  
21 State of California  
22 Complainant  
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